Checklist 3 – Separation Physical

Form	Examinee Completed	Physician Completed
DD Form 2697, Report of Medical Assessment		
DD Form 2807-1, Report of Medical History		
DD Form 2808, Report of Medical Examination		
DA Form 4700, Medical Record Supplement – Hepatitis C Screening		
HIV (AIDS Virus) Testing		
Memo for Commander		
EKG (Automated Version of OF 520)		
Separation Statement Option		

_____ **Part II: Date and Time:** _____

Last Name / Last 4

This packet has been prepared to assist you in completing your physical examination. Please finish all clinic visits checked below prior to Part II so that the physician can review al of the test results with you. NOTE: Fill in all forms as per instructions. If you have any problems or questions call 433-3345 for assistance.

___ **LABORATORY** (blood and urine tests) Wing G, 4th Floor. Phone: 433-6664

___ **AUDIOLOGY CLINIC** (hearing test) Wing C, 3rd Floor. APPOINTMENT at: _____ (BY APPOINTMENT ONLY). Active Duty personnel must have their medical records.

___ **OPTOMETRY CLINIC** (vision screening) Wing C, 2nd Floor. Times: Wed and Fri 0800-1100. PLEASE BRING YOUR GLASSES IF YOU WEAR CORRECTIVE LENSES. Phone: 433-3211

___ **CARDIOLOGY CLINIC** (EKG) Wing A, 4th Floor. Phone: 433-6390. CLOSED THURSDAY AND FRIDAY AFTER 1300

___ **RADIOLOGY** (X-ray) Wing G, 3rd Floor. Phone: 433-6669

___ **GYN CLINIC** (GYN exam) Wing H, 4th Floor. BY APPOINTMENT ONLY. Phone: 433-2778 for a "Well Woman Exam" appointment.

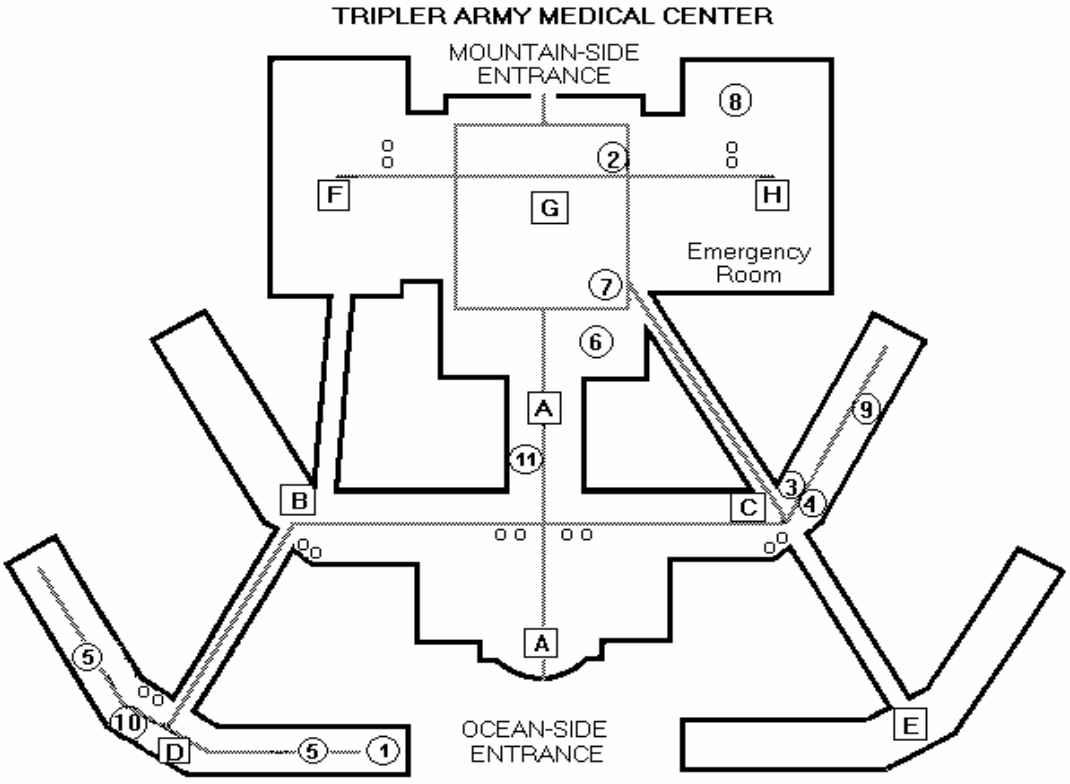
___ **FAMILY MEDICINE CLINIC** (height, weight, blood pressure, pulse) Wing D, 1st Floor.

___ **DENTAL CLINIC** (dental exam) Wing D, Ground Floor (G1). Times: Mon-Fri 0730-0900. Phone: 433-5370

___ **PULMONARY CLINIC** (PFT's) Wing A, 4th Floor (Rm.# 4A 308). Mon-Thur 1300-1500. Phone: 433-6627

___ **IMMUNIZATION CLINIC** (TB test) Wing C, 4th Floor. Times: Mon, Tues, Wed, Fri 0800-0900 Phone: 433-6334

___ **TREASURER'S OFFICE** (obtain authorization) Wing H, 3rd Floor. Phone: 433-6100



KEY TO MAP

1 Physical Exam Clinic
2 Laboratory
3 Audiology Clinic
4 Optometry Clinic
5 Family Medicine Clinic
6 Cardiology/Pulmonary Clinics
7 Radiology Dept
8 GYN Clinic
9 Immunization Clinic
10 FMC Frontdesk
11 Occupational Health Clinic

oo = **Elevators**

Instructions for completion of DD Form 2697, Report of Medical Assessment (Use black ballpoint pen)

Item #	
1 to 19	Self-explanatory

REPORT OF MEDICAL ASSESSMENT

REPORT CONTROL SYMBOL
DD-HA(AR)1939

PRIVACY ACT STATEMENT

AUTHORITY: PL 103-160, EO 9397.
PRINCIPAL PURPOSE: To be used by the Medical Services to provide a comprehensive medical assessment for active and reserve component service members separating or retiring from active duty.
ROUTINE USES: A copy of this form will be released to the Department of Veterans Affairs.
DISCLOSURE: Voluntary; however, failure to disclose the requested personal information may result in delay in processing any disability claim.

SECTION I - TO BE COMPLETED BY SERVICE MEMBER. Any service member who requests a physical examination may have one.

1. NAME *(Last, First, Middle)*	2. SOCIAL SECURITY NUMBER	3. RANK

4. COMPONENT	5. UNIT OF ASSIGNMENT

6a. HOME STREET ADDRESS *(Or RFD, including apartment number)*	b. CITY	c. STATE	d. ZIP CODE	7. HOME TELEPHONE NUMBER *(Include area code)*

8. DATE OF LAST PHYSICAL EXAMINATION BY THE MILITARY *(YYMMDD)*	9. DATE ENTERED ON CURRENT ACTIVE DUTY *(YYMMDD)*

10. COMPARED TO MY LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, MY OVERALL HEALTH IS *(X one. If "Worse," explain)*

- ☐ **THE SAME**
- ☐ **BETTER**
- ☐ **WORSE**

11. SINCE YOUR LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, HAVE YOU HAD ANY ILLNESSES OR INJURIES THAT CAUSED YOU TO MISS DUTY FOR LONGER THAN 3 DAYS? *(X one. If "Yes," explain.)*

- ☐ **NO**
- ☐ **YES**

12. SINCE YOUR LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, HAVE YOU BEEN SEEN BY OR BEEN TREATED BY A HEALTH CARE PROVIDER, ADMITTED TO A HOSPITAL, OR HAD SURGERY? *(X one. If "Yes," explain.)*

- ☐ **NO**
- ☐ **YES**

13. HAVE YOU SUFFERED FROM ANY INJURY OR ILLNESS WHILE ON ACTIVE DUTY FOR WHICH YOU DID NOT SEEK MEDICAL CARE? *(X one. If "Yes," explain.)*

- ☐ **NO**
- ☐ **YES**

14. ARE YOU NOW TAKING ANY MEDICATIONS? *(X one. If "Yes," list medications.)*

- ☐ **NO**
- ☐ **YES**

15. DO YOU HAVE ANY CONDITIONS WHICH CURRENTLY LIMIT YOUR ABILITY TO WORK IN YOUR PRIMARY MILITARY SPECIALTY OR REQUIRE GEOGRAPHIC OR ASSIGNMENT LIMITATIONS? *(X one. If "Yes," explain.)*

- ☐ **NO**
- ☐ **YES**

16. DO YOU HAVE ANY DENTAL PROBLEMS? *(X one. If "Yes," explain.)*

- ☐ **NO**
- ☐ **YES**

17. DO YOU HAVE ANY OTHER QUESTIONS OR CONCERN ABOUT YOUR HEALTH? *(X one. If "Yes," explain.)*

- ☐ **NO**
- ☐ **YES**

18. AT THE PRESENT TIME, DO YOU INTEND TO SEEK DEPARTMENT OF VETERANS AFFAIRS (VA) DISABILITY? *(X one. If "Yes," list conditions for which you will ask for VA Disability.)*

- ☐ **NO**
- ☐ **YES**
- ☐ **UNCERTAIN**

19. CERTIFICATION. I certify that the information provided above is true and complete to the best of my knowledge.

a. SIGNATURE OF SERVICE MEMBER	b. DATE SIGNED

SECTION II - TO BE COMPLETED BY INDIVIDUALLY PRIVILEGED HEALTH CARE PROVIDER

This Report of Medical Assessment is to be used by the Medical Services to provide a comprehensive medical assessment for active and reserve component service members separating or retiring from active duty. The assessment will cover, as a minimum, the period since the service member's last medical assessment/physical examination, or the period of this call or order to active duty. Any service member who requests a physical examination may have one. Any service member who has indicated "yes" to Item 18 will have an appropriate physical examination, if the last examination is more than 12 months old and/or there are new signs and/or symptoms. If the service member answers "Worse" to Item 10 or "Yes" to Items 11, 12, or 14 through 18, documentation of the injury, illness, or problem should be included in the service member's medical or dental record.

20. HEALTH CARE PROVIDER COMMENTS *(All patient complaints must be addressed)*

21. WAS PATIENT REFERRED FOR FURTHER EVALUATION? *(X one. If "Yes," specify where.)*

- [ ] **NO**
- [ ] **YES**

22. PURPOSE OF ASSESSMENT *(X one. If "Other," explain.)*

- [ ] **SEPARATION** *(Includes discharge from military service and release from active duty, including release of National Guard and Reserve personnel voluntarily or involuntarily called or ordered to active duty.)*
- [ ] **RETIREMENT**
- [ ] **OTHER**

23. MEDICAL FACILITY	**24. DATE OF ASSESSMENT** *(YYMMDD)*
Tripler Army Medical Center	

25. HEALTH CARE PROVIDER

a. NAME *(Last, First, Middle Initial)*	**b. GRADE/RANK**	**c. SIGNATURE**

Instructions for completion of DD Form 2807-1, Report of Medical History **(Use black ballpoint pen)**

Item #	
1 and 2	Self-explanatory
3	Today's Date – **LEAVE BLANK** (this will be filled in by the examiner when you return for Part II
4a	Current address, not "home of record"
4b	Self-explanatory
5	**Leave blank** (this will be completed by the examiner)
6 to 9	Self-explanatory
10 – 28	Mark "YES" or "NO"
29	If any answer is "YES" (questions 10 to 28), write a brief summary of the problem including: 1) date(s) of illness, injury, surgery, etc.; 2) diagnosis, if known; 3) treatment (medication, physical therapy, etc.); and 4) current medical status.
30	**Leave blank** (this will be completed by the examiner)

Fill in **NAME** and **SOCIAL SECURITY NUMBER** at the top of pages 2 and 3

REPORTOF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

Form Approved
OMB No. 0704-0413
Expires Oct 31, 2006

PLEASEDO NOT RETURNYOUR FORM TO THE ABOVE ORGANIZATION. RETURNCOMPLETEDFORM AS INDICATED ON PAGE2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397 (SSAN).
PRINCIPALPURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.
ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a $10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2. SOCIAL SECURITY NUMBER	3. TODAY'S DATE *(YYYYMMDD)*

4.a. HOME ADDRESS *(Street, Apartment No., City, State, and ZIP Code)*

b. HOME TELEPHONE*(Include Area Code)*

5. EXAMINING LOCATION AND ADDRESS *(Include ZIP Code)*
Physical Examination Clinic
Department of Family Medicine and Emergency Medical Services
Tripler Army Medical Center
1 Jarrett White Road
Tripler AMC, HI 96859-5000

X ALL APPLICABLEBOXES:

6.a. SERVICE
- ☐ Army
- ☐ Navy
- ☐ Marine Corps
- ☐ Air Force
- ☐ Coast Guard

b. COMPONENT
- ☐ Active Duty
- ☐ Reserve
- ☐ National Guard

c. PURPOSEOF EXAMINATION
- ☐ Enlistment
- ☐ Commission
- ☐ Retention
- ☐ Separation
- ☐ Medical Board
- ☐ Retirement
- ☐ U.S. Service Academy
- ☐ ROTC Scholarship Program
- ☐ Other *(Specify)*

7.a. POSITION *(Title, Grade, Component)*

b. USUAL OCCUPATION

8. CURRENTMEDICATIONS *(Prescription and Over-the-counter)*

9. ALLERGIES*(Including insect bites/stings, foods, medicine or other substance)*

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVERHAD OR DO YOU NOW HAVE:	YES	NO
10. a. Tuberculosis	○	○
b. Lived with someone who had tuberculosis	○	○
c. Coughed up blood	○	○
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	○	○
e. Shortness of breath	○	○
f. Bronchitis	○	○
g. Wheezing or problems with wheezing	○	○
h. Been prescribed or used an inhaler	○	○
i. A chronic cough or cough at night	○	○
j. Sinusitis	○	○
k. Hay fever	○	○
l. Chronic or frequent colds	○	○
11. a. Severe tooth or gum trouble	○	○
b. Thyroid trouble or goiter	○	○
c. Eye disorder or trouble	○	○
d. Ear, nose, or throat trouble	○	○
e. Loss of vision in either eye	○	○
f. Worn contact lenses or glasses	○	○
g. A hearing loss or wear a hearing aid	○	○
h. Surgery to correct vision *(RK, PRK, LASIK, etc.)*	○	○
12. a. Painful shoulder, elbow or wrist *(e.g. pain, dislocation, etc.)*	○	○
b. Arthritis, rheumatism, or bursitis	○	○
c. Recurrent back pain or any back problem	○	○
d. Numbness or tingling	○	○
e. Loss of finger or toe	○	○

12. *(Continued)*	YES	NO
f. Foot trouble *(e.g., pain, corns, bunions, etc.)*	○	○
g. Impaired use of arms, legs, hands, or feet	○	○
h. Swollen or painful joint(s)	○	○
i. Knee trouble *(e.g., locking, giving out, pain or ligament injury, etc.)*	○	○
j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	○	○
k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	○	○
l. Bone, joint, or other deformity	○	○
m. Plate(s), screw(s), rod(s) or pin(s) in any bone	○	○
n. Broken bone(s) *(cracked or fractured)*	○	○
13. a. Frequent indigestion or heartburn	○	○
b. Stomach, liver, intestinal trouble, or ulcer	○	○
c. Gall bladder trouble or gallstones	○	○
d. Jaundice or hepatitis *(liver disease)*	○	○
e. Rupture/hernia	○	○
f. Rectal disease, hemorrhoids or blood from the rectum	○	○
g. Skin diseases *(e.g. acne, eczema, psoriasis, etc.)*	○	○
h. Frequent or painful urination	○	○
i. High or low blood sugar	○	○
j. Kidney stone or blood in urine	○	○
k. Sugar or protein in urine	○	○
l. Sexually transmitted disease *(syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)*	○	○
14. a. Adverse reaction to serum, food, insect stings or medicine	○	○
b. Recent unexplained gain or loss of weight	○	○
c. Currently in good health *(If no, explain in Item 29 on Page 2.)*	○	○
d. Tumor, growth, cyst, or cancer	○	○

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
15. a. Dizziness or fainting spells	○	○
b. Frequent or severe headache	○	○
c. A head injury, memory loss or amnesia	○	○
d. Paralysis	○	○
e. Seizures, convulsions, epilepsy or fits	○	○
f. Car, train, sea, or air sickness	○	○
g. A period of unconsciousness or concussion	○	○
h. Meningitis, encephalitis, or other neurological problems	○	○
16. a. Rheumatic fever	○	○
b. Prolonged bleeding *(as after an injury or tooth extraction, etc.)*	○	○
c. Pain or pressure in the chest	○	○
d. Palpitation, pounding heart or abnormal heartbeat	○	○
e. Heart trouble or murmur	○	○
f. High or low blood pressure	○	○
17. a. Nervous trouble of any sort *(anxiety or panic attacks)*	○	○
b. Habitual stammering or stuttering	○	○
c. Loss of memory or amnesia, or neurological symptoms	○	○
d. Frequent trouble sleeping	○	○
e. Received counseling of any type	○	○
f. Depression or excessive worry	○	○
g. Been evaluated or treated for a mental condition	○	○
h. Attempted suicide	○	○
i. Used illegal drugs or abused prescription drugs	○	○
18. FEMALES ONLY. Have you ever had or do you now have:		
a. Treatment for a gynecological (female) disorder	○	○
b. A change of menstrual pattern	○	○
c. Any abnormal PAP smears	○	○
d. First day of last menstrual period *(YYYYMMDD)*		
e. Date of last PAP smear *(YYYYMMDD)*		

	YES	NO
19. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.	○	○
b. Inability to perform certain motions	○	○
c. Inability to stand, sit, kneel, lie down, etc.	○	○
d. Other medical reasons *(If yes, give reasons.)*	○	○
20. Have you ever been treated in an Emergency Room? *(If yes, for what?)*	○	○
21. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*	○	○
22. Have you ever had, or have you been advised to have any operations or surgery? *(If yes, describe and give age at which occurred.)*	○	○
23. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*	○	○
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*	○	○
25. Have you ever been rejected for military service for any reason? *(If yes, give date and reason for rejection.)*	○	○
26. Have you ever been discharged from military service for any reason? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)*	○	○
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? *(If yes, specify what kind, granted by whom, and what amount, when, why.)*	○	○
28. Have you ever been denied life insurance?	○	○

29. EXPLANATION OF "YES" ANSWER(S) *(Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)*

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

30. EXAMINER'S SUMMARY AND ELABORATIONOF ALL PERTINENTDATA *(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)*

a. COMMENTS

b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*

Instructions for completion of DD Form 2808, Report of Medical Examination **(Use black ballpoint pen)**

Item #	
1	Date of Examination – **LEAVE BLANK** (this will be filled in by the examiner when you return for Part II)
2 and 3	Self-explanatory
4	Current address, not “home of record”
5 to 11	Self-explanatory
12	Agency (Non-Service Members Only) – Peace Corps, U.S. State Dept, NOAA, etc.
13	Self-explanatory
14a to 14c	Leave blank (for aviators only)
15a to 15c	Self-explanatory
16 to 86	**Leave blank** to be filled in by examiner

Fill in **NAME** and **SOCIAL SECURITY NUMBER** at the top of pages 2 and 3

REPORTOF MEDICAL EXAMINATION

1. DATE OF EXAMINATION (YYYYMMDD)	2. SOCIAL SECURITY NUMBER

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.
PRINCIPALPURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.
ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	4. HOME ADDRESS *(Street, Apartment Number, City, State and ZIP Code)*	5. HOME TELEPHONE NUMBER *(Include Area Code)*

6. GRADE	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9. SEX	10.a. RACIAL CATEGORY *(X one or more)*				b. ETHNIC CATEGORY	
			☐ Female ☐ Male	☐ American Indian or Alaska Native ☐ Asian	☐ Black or African American ☐ White	☐ Native Hawaiian or Other Pacific Islander ☐ Decline to Respond		☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Decline to Respond

11. TOTAL YEARS GOVERNMENT SERVICE		12. AGENCY *(Non-Service Members Only)*	13. ORGANIZATION UNIT AND UIC/CODE
a. MILITARY	b. CIVILIAN		

14.a. RATING OR SPECIALTY *(Aviators Only)*	b. TOTAL FLYING TIME	c. LAST SIX MONTHS

15.a. SERVICE	b. COMPONENT	c. PURPOSEOF EXAMINATION	16. NAME OF EXAMINING LOCATION, AND ADDRESS *(Include ZIP Code)*
☐ Army ☐ Coast Guard ☐ Navy ☐ Marine Corps ☐ Air Force	☐ Active Duty ☐ Reserve ☐ National Guard	☐ Enlistment ☐ Medical Board ☐ Other ☐ Commission ☐ Retirement ☐ Retention ☐ U.S. Service Academy ☐ Separation ☐ ROTC Scholarship Program	Physical Exam Clinic, Dept of Fam Med & Emer Med Svcs, Tripler AMC 1 Jarrett White Road Tripler AMC, Hawai'i 96859-5000

CLINICAL EVALUATION *(Check each item in appropriate column. Enter "NE" if not evaluated.)*

	Normal	Abnorm	NE
17. Head, face, neck, and scalp			
18. Nose			
19. Sinuses			
20. Mouth and throat			
21. Ears - General *(Int. and ext. canals/Auditory acuity under item*			
22. Drums *(Perforation)*			
23. Eyes - General *(Visual acuity and refraction under items 61 - 63)*			
24. Ophthalmoscopic			
25. Pupils *(Equality and reaction)*			
26. Ocular motility *(Associated parallel movements, nystagmus)*			
27. Heart *(Thrust, size, rhythm, sounds)*			
28. Lungs and chest *(Include breasts)*			
29. Vascular system *(Varicosities, etc.)*			
30. Anus and rectum *(Hemorrhoids, Fistulae) (Prostate if indicated)*			
31. Abdomen and viscera *(Include hernia)*			
32. External genitalia *(Genitourinary)*			
33. Upper extremities			
34. Lower extremities *(Except feet)*			
35. Feet *(See Item 35 Continued)*			
36. Spine, other musculoskeletal			
37. Identifying body marks, scars, tattoos			
38. Skin, lymphatics			
39. Neurologic			
40. Psychiatric *(Specify any personality deviation)*			
41. Pelvic *(Females only)*			
42. Endocrine			

44. NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)*

43. DENTAL DEFECTS AND DISEASE *(Please explain. Use dental form if completed by dentist. If dental examination not done by dental officer, explain in Item 44.)*

☐ Acceptable
☐ Not Acceptable Class _____

35. FEET *(Continued) (Circle category)*

Normal Arch	Mild	Asymptomatic
Pes Cavus	Moderate	
Pes Planus	Severe	Symptomatic

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

LABORATORY FINDINGS

45. URINALYSIS	a. Albumin	46. URINE HCG	47. H/H	48. BLOOD TYPE
	b. Sugar			

TESTS	RESULTS	HIV SPECIMEN ID LABEL	DRUG TEST SPECIMEN ID LABEL
49. HIV			
50. DRUGS			
51. ALCOHOL			
52. OTHER			
a. PAP SMEAR			
b. Urine Micro			
c.			

MEASUREMENTS AND OTHER FINDINGS

53. HEIGHT	54. WEIGHT lbs.	55. MIN WGT - MAX WGT MAX BF %	56. TEMPERATURE	57. PULSE

58. BLOOD PRESSURE			59. RED/GREEN *(Army Only)*	60. OTHER VISION TEST
a. 1ST	b. 2ND	c. 3RD		
SYS.	SYS.	SYS.		
DIAS.	DIAS.	DIAS.		

61. DISTANT VISION	62. REFRACTION BY AUTOREFRACTION OR MANIFEST	63. NEAR VISION
Right 20/ Corr. to 20/	By S. CX	Right 20/ Corr. to 20/ by
Left 20/ Corr. to 20/	By S. CX	Left 20/ Corr. to 20/ by

64. HETEROPHORIA *(Specify distance)*

ES° EX° R.H. L.H. Prism div. Prism Conv CT NPR PD

65. ACCOMMODATION		66. COLOR VISION *(Test used and result)*	67. DEPTH PERCEPTION *(Test used and score)* AFVT	
Right	Left	PIP /14	Uncorrected	Corrected

68. FIELD OF VISION	69. NIGHT VISION *(Test used and score)*	70. INTRAOCULAR TENSION	
		O.D.	O.S.

71a. AUDIOMETER	Unit Serial Number						71b. Unit Serial Number							72a. READING ALOUD TEST
Date Calibrated *(YYYYMMDD)*							Date Calibrated *(YYYYMMDD)*							☐ SAT ☐ UNSAT
HZ	500	1000	2000	3000	4000	6000	HZ	500	1000	2000	3000	4000	6000	
Right							Right							72b. VALSALVA
Left							Left							☐ SAT ☐ UNSAT

73. NOTES *(Continued)* **AND SIGNIFICANT OR INTERVAL HISTORY** *(Use additional sheets if necessary.)*

HDL: _____ LDL: _____ TG: _____ CHOL: _____ FBS: _____ RPR: _____ G6PD: _____

WBC: _____ Hgb: _____ Hct: _____ PSA: _____ Sickle Cell: _____ Anti-HCV: _____

Occult Blood: _____

SMOKING HISTORY

_____ Never Smoked _____ Ex-smoker; quit how long ago? _____

_____ Current smoker: number of cigarettes per day _____ _____ Cigar smoker: number of cigars per day _____

EKG:

Chext X-ray:

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

74.a. EXAMINEE/APPLICANT *(check one)*

- ☐ IS QUALIFIED FOR SERVICE
- ☐ IS NOT QUALIFIED FOR SERVICE

75. I have been advised of my disqualifying condition.

a. SIGNATURE OF EXAMINEE	b. DATE *(YYYYMMDD)*

b. PHYSICAL PROFILE

P	U	L	H	E	S	X	PROFILER INITIALS	DATE *(YYYYMMDD)*

76. SIGNIFICANT OR DISQUALIFYING DEFECTS

ITEM NO.	MEDICAL CONDITION/DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE *(YYYYMMDD)*	QUALI-FIED	DIS-QUALI-FIED	EXAMINER INITIALS	WAIVER RECEIVED	
								SERVICE	DATE *(YYYYMMDD)*

77. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers) (Use additional sheets if necessary.)*

78. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify) (Use additional sheets if necessary.)*

79. MEPS WORKLOAD *(For MEPS use only)*

WKID	ST	DATE *(YYYYMMDD)*	INITIAL	WKID	ST	DATE *(YYYYMMDD)*	INITIAL

80. MEDICAL INSPECTION DATE	HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	PHYSICIAN'S SIGNATURE

81.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE

82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE

83.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	b. SIGNATURE

84.a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY	b. SIGNATURE

85. This examination has been administratively reviewed for completeness and accuracy.

a. SIGNATURE	b. GRADE	c. DATE *(YYYYMMDD)*

86. WAIVER GRANTED *(If yes, date and by whom)*

- ☐ **YES**
- ☐ **NO**

87. NUMBER OF ATTACHED SHEETS

Instructions for completion of DA Form 4700, Medical Record-Supplemental Medical Data, Report Title – Hepatitis C Screening **(Use black ballpoint pen)**

1. Read statement sign and date.

2. Fill-in patient's identification at bottom of form.

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE	OTSG APPROVED *(Date)* *(YYYYMMDD)*
HEPATITIS C SCREENING	

The following statement will be enclosed in the medical record of all soldiers who are separating or retiring from active duty. Soldiers will be instructed to read the statement and indicate in the space provided whether or not they want to be screened for Hepatitis C infection.

1. Hepatitis C virus (HCV) is transmitted primarily by injections (for example, blood transfusions, contaminated needles, or sticks with contaminated sharp objects) of contaminated blood. The following are possible sources of HCV infection. If you can answer "yes" to any of these risk factors, you should receive a simple blood test (HCV antibody test) to determine if you could have HCV.

2. Risk Factors:

a. Receiving a transfusion of blood or blood products before 1992.

b. Ever injecting illegal drugs, including use once many years ago.

c. Receiving clotting factor concentrates produced before 1987.

d. Having chronic (long term) hemodialysis.

e. Being told that you have persistent abnormal liver enzyme tests (alanine aminotransferase) or an unexplained liver disease.

f. Receiving an organ transplant before July 1992.

g. Having a needle stick, sharps or mucosal exposure to potentially HCV infected blood as part of your occupational duties and not been previously evaluated for HCV infection.

3. If you consider yourself at risk, based on an exposure to a possible source of HCV, you should have a simple blood test for HCV. You may request HCV testing even if you don't have a specific risk factor for infection. You will not be asked to identify any specific risk factor to justify HCV testing.

4. If the test is positive, you will receive a medical evaluation to confirm HCV infection, your need for specific treatments will be determined, and you will be provided counseling on lifestyle modifications and steps to protect others from infection.

5. Circle your response below and sign and date.

a. No -- I do not want to be tested for HCV.

b. Yes -- I want to be tested for HCV.

Signature: _____ Date:_____

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	*DATE (YYYYMMDD)*
	Physical Examination Clinic	

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)*

Tripler Army Medical Center

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☒ DIAGNOSTIC STUDIES
- ☐ TREATMENT

PATIENT INSTRUCTIONS
FOR HIV (AIDS VIRUS) TESTING

1. The Army has a program to routinely screen patients for infection with Human Immunodeficiency Virus (HIV), the virus which causes Acquired Immune Deficiency Syndrome (AIDS). Routine testing assists physicians and other health care providers in being fully aware of a patient's health status. A person who is infected with HIV could have adverse reactions to certain treatments. Additionally, early identification of infected patients may help to prevent the spread of infection.

2. HIV screening is mandatory for active duty (AD) military members. AD military members will have their blood drawn and tested for HIV unless there is military documentation of a test result in the previous twelve months.

3. The HIV screening test is voluntary for non-active duty patients. These patients have the right to refuse this test.

4. No patient who declines to be tested for HIV will be denied appropriate care.

5. The screening test for HIV requires that a blood sample be obtained using a needle.

6. The blood sample is tested for evidence of HIV infection. A positive test does not mean that one has, or will develop the disease AIDS.

7. A NEGATIVE TEST means that no evidence of HIV has been detected in your blood. There are two possible explanations for this:

-- You have not been infected by the virus.
-- Or you have recently been infected by HIV and are capable of transmitting the virus to others, but your blood test has not yet become positive.

NOTE: It may take as long as three weeks to get the results of a negative test.

8. A POSITIVE TEST means that:

-- You have been infected with HIV.
-- You can pass the virus on to others by having sex, sharing needles, becoming pregnant, or donating blood or organs.

9. If your test is positive you will be notified by your doctor and will receive additional medical evaluation, counseling and treatment as indicated.

10. The results of a positive HIV test will be placed in your medical record and appropriate persons involved in health care will have access to that information. The results of the HIV antibody test are considered confidential and shall not be released without your

written permission, except to the individuals and organizations who are authorized access under state and federal laws or regulations.

11. For more health care information visit Tripler's Health education Center located on the 1st floor, ocean side entrance, next to the Community Library in Room 1A-001. Hours of operations are Monday thru Friday 0900 – 1700 and Saturday 1100 – 1500. For more information, call 433-2176/2565.

CHCS version of HIV Testing

CONSENT FOR HIV (AIDS VIRUS) TESTING
(Patient Medical Record Copy)

I have been counseled and given written information concerning HIV testing and understand the content. I have also been given the opportunity to ask questions.

_____ Yes, I agree to have my blood tested for HIV.

_____ No, I decline to have my blood tested for HIV.

Signature _____ Date _____

Printed Name _____

==========

SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent)

I, _____ sponsor/guardian of _____

agree to / decline HIV testing.
(circle choice)

Signature _____ Date _____

Printed Name _____

==========

HEALTH CARE PROVIDER: I have counseled _____ concerning HIV testing.

Signature of Provider _____ Date _____

DEPARTMENT OF THE ARMY
HEADQUARTERS, TRIPLER ARMY MEDICAL CENTER
1 JARRETT WHITE ROAD
Tripler AMC, Hawaii 96859-5000

REPLY TO ATTENTION OF

MEDICAL EXAMINATION FOR SEPARATION STATEMENT OF OPTION

I understand that I am not required to undergo a medical examination for separation from active duty; however, I may request a physical examination. If I elect not to undergo a separation examination, I also understand that my medical records or my completed and signed DD Form 2697 will be reviewed by a physician at the appropriate medical treatment facility; and if the review indicates that an examination should be accomplished, I will be scheduled for an examination based on the results of the review.

I (___ do) (___ do not) desire a separation medical examination.

_____ _____
(Name & Rank) (SSN)

_____ _____
(Signature) (Date)

_____
(Unit of Assignment)

If you do not desire a separation medical examination, please have a physician complete the following statement:

The medical records or DD Form 2697 of the above named individual has been reviewed under the provisions of AR 40-501. Determination has been made that a medical examination for separation (___ is) (___ is not) required.

_____
(Date)

KEITH W. HADEN, M.D.
Chief, Physical Examination Clinic